AUTHORIZATION OF RELEASE OF INFORMATION

Name: _____

Address: _____

Authorization: I, _____, hereby authorize any physician or hospital, or any other person, institution, corporation, or Government activity to furnish any desired information to the US Department of Labor Office of Workers' Compensation Programs or its official representative. This authorization also permits any official representative of such office to examine and to copy any records pertaining to or concerning me.

_____ _____

Signature Date

Figure 810-2. Authorization Form